



State Board of Medical Examiners

Division of Consumer Affairs
N.J. Department of Law and Public Safety
140 E. Front Street, P.O. Box 183
Trenton, N.J. 08608

STATE BOARD OF MEDICAL EXAMINERS

Issue 29

NEWSLETTER

Fall 2000

Formation of Bioethics Committee

By B. Robins

The New Jersey State Board of Medical Examiners has established a permanent Bioethics Committee composed of Board members as well as licensees, representatives from other agencies of State government, and knowledgeable individuals from the community with bioethical expertise.

The first meeting of the committee took place on February 3, 1999, and there have been a series of subsequent meetings. The initial topics for study by working groups of the committee were confidentiality, doctor/patient relationships and pain management.

Recommendations have been made to the Board and appropriate policies and regulations may be developed, as necessary. Furthermore, the group will play a significant role in advising the Board on crucial bioethical issues in the future.

The New Jersey State Board of Medical Examiners is the first state medical board in the nation to embark on such a venture.

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An Overview of the Disciplinary Process

By Glenn A. Farrell, Esq.

You are reading your mail on a Saturday morning. You open a letter from the New Jersey State Board of Medical Examiners (Board) and it requests that you appear before a Preliminary Evaluation Committee (PEC) of the Board. Your requested appearance relates to a complaint filed by a patient. What is a PEC? What is going to happen? These are questions which are frequently asked by licensees about investigative proceedings. This article will provide a brief overview of the Board's disciplinary process.

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Office of the Insurance Fraud Prosecutor

The Office of Insurance Fraud Prosecutor (OIFP) was created as part of the Automobile Insurance Cost Reduction Act (AICRA). OIFP has been charged with investigating all types of health-care fraud and serves as the focal point for all criminal, civil and administrative prosecutions for insurance and Medicaid fraud. OIFP has also been charged with coordinating all insurance fraud-related activities of State and local departments and agencies to enhance the State's integrated law enforcement system.

OIFP works closely with deputy attorneys general from the Division of Law, investigators with the Division of Consumer Affairs' Enforcement Bureau and the professional and occupational boards. Despite their extensive training and education, licensees of the professional and occupational boards may be tempted to exploit their positions of authority and engage in fraudulent acts. This conduct may include utilizing a professional license to bill for services not rendered, upcoding CPT codes, overutilization of services to increase fees for services, as well as billing two separate insurance carriers for the same services. Illegally adding a non-eligible person to a group health policy or submitting bogus personal medical bills to the licensee's personal health insurance carrier also constitutes insurance fraud. The fraudulent act may also involve participating in staged auto accidents or making material misstatements on an automobile insurance policy.

Professional licensees are subject to civil penalties if it is determined that they engaged in insurance fraud. Furthermore, the fraudulent act may be judged to be criminal and may result in a criminal conviction, incarceration or probation and fines. Civil or criminal enforcement action will cause OIFP to refer the matter to the appropriate professional or occupational board for the initiation of an administrative disciplinary action. Boards can utilize the action taken by OIFP as sister-agency disciplinary action and file an administrative complaint based solely on the OIFP action. Sanctions range from reprimand to revocation of licensure.

OIFP has made significant strides in making its law enforcement presence known, including conducting an advertising campaign and publicizing the fact that insurance and Medicaid fraud are serious crimes which will result in serious consequences for those who commit such fraud in New Jersey.

By Christine Danser, CNM, MSN

The Publications/Public Relations Committee is a recently formed committee of the State Board of Medical Examiners. Its mission is to educate Board licensees and their patients about the Board's advocacy role to both parties in an attempt to improve relations among the three groups. The Board's newsletter will serve as the means to communicate with licensees and the public, and will be published regularly for more frequent communication from the Board. The members of the Publications/Public Relations Committee include Committee Chairman Ricardo J. Fernandez, MD; Bernard Robins, MD; Christine Danser, CNM, MS; Veronica Desmond, public member; Glenn A. Farrell, Esq., public member; and Kevin Walsh, PA. We welcome your feedback, questions and comments.

News Briefs is a new feature of the Newsletter. It will provide newsworthy information on Board actions, members and events and will appear in every issue. We hope you find it to be a quick and interesting update!

The Bioethics Committee is another new committee of the Board. Please refer to Dr. Robins's column in this issue for more information concerning this new venture.

A rule amendment that stipulates the requirements allowing certified nurse midwives (CNM's) to act as first assistants for the performance of cesarean births (sections) has been published and became effective on February 22, 2000. The first course designed in accordance with the regulation to prepare CNM's to provide first assistance was held in November 1999 with 50 CNM's attending. Pertinent portions of the amended rule follow:

13:35-4.1 Major surgery; qualified first assistant

(a)-(b) (No change.)

(c) In addition to those individuals listed in (b) above who may act as qualified first assistants, in a health care facility licensed by the Department of Health and Senior Services, a duly qualified registered nurse first assistant (RNFA) or a duly qualified physician assistant may so act. A duly qualified certified nurse midwife (CNM) may also act as a qualified first assistant in the performance of cesarean sections. For

purposes of this subsection, a licensed CNM shall be deemed to be "duly qualified" provided that the CNM has taken and passed a 30-hour didactic training course that includes anatomy, physiology, surgical technique (including wound closure), and direct observation of cesarean sections. Following the completion of the course, a CNM shall serve and be supervised as a second assistant on 10 cesarean sections and complete a supervised preceptorship as a first assistant in 20 cesarean sections.

(d) A duly qualified surgeon, duly qualified assistant physician, duly qualified resident, duly qualified registered nurse first assistant, duly qualified physician assistant, or duly qualified certified nurse midwife (CNM) shall be determined by the hospital credentials committee in conjunction with the chairman or chief of the appropriate department or division consistent with the requirements of law or applicable rule.

(e) (No change.)

(f) In all instances in which a registered nurse first assistant, a physician assistant, or a certified nurse midwife (CNM) may act as first assistant pursuant to (c) above, the operating surgeon shall have discretion to determine whether to utilize such an individual as a first assistant, despite the fact that they are permitted to so act pursuant to this rule.

(g) (No change.)

A joint committee comprised of representatives from the New Jersey Board of Nursing, nurse practitioners/clinical nurse specialists and members of the State Board of Medical Examiners met and designed proposed standards for joint protocols between nurse practitioners/clinical nurse specialists and collaborating physicians. The joint protocols were published in the New Jersey Register on June 7, 1999. The joint committee met in January 2000 to review and prepare responses to the public comments received regarding the proposed new rules. More information on this matter will appear in News Briefs in the next newsletter produced by the State Board of Medical Examiners.

Disciplinary Actions

The following disciplinary actions were ordered by the New Jersey State Board of Medical Examiners in 1999:

Suspensions

January

- 1) *Robert B. Levin, MD*; based on sexual boundary violations with a psychiatric patient (effective 8/12/98 for an indefinite period).

February

- 2) *Michael P. Stein, MD*; based on fraudulent acquisition of CDS (effective 2/4/99 for five years with one year active and the remainder served as a period of probation).

March

- 3) *Paul Keshishian, DO*; based on offering diagnostic radiology services performed by persons who are not physicians or licensed radiologic technologists, offering grossly negligent service, proffering professional medical service through a corporation which was not licensed to offer such services (effective 1/15/99 for three years with nine months' active and the remainder served as a period of probation).

April

- 4) *Jeffrey Askanazi, MD*; based on the suspension of his Michigan license due to violation of general duty consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees and other individuals; incompetence; lack of good moral character; unprofessional conduct consisting of promotion for personal gain of an unnecessary drug, device, treatment, procedure or service (effective 4/14/99 for an indefinite period).
- 5) *Chun Chung Chan, MD*; based on revocation of his California license upon admission to acts of gross negligence and repeated negligent acts (effective 4/20/99 for five years, stayed).

May

- 6) *Benjamin Greenberg, MD*; based on the surrender of his New York license and his failure to appear before the New Jersey State Board, as well as his failure to respond to a Provisional Order of Discipline (effective 5/12/99 for an indefinite period).

- 7) *Steven W. Sarner, MD*; based on sexually inappropriate conduct and language of a grossly unprofessional nature which was directed at three professional female colleagues and which constituted professional misconduct and other violations of law; failure to cooperate in a Board preliminary investigation (effective 5/13/98 for three years).

- 8) *Jaime Ligot, MD*; based on allegations of failure to ensure the safety and confidentiality of his patient and medical records; failure to ensure prescription pad control; improper dispensing of medication to patients; violation of the Board's corporate practice regulations by practicing in the employ of several unlicensed individuals (effective 5/14/99 for three years, stayed).

June

- 9) *Evangelos Megariotis, MD*; based on performing surgery which was both unnecessary and resulted in a permanent disabling of the patient's elbow; repeated dispensing of drugs or medicines in excess of a seven-day supply, and as consideration of such dispensing, repeatedly charging a sum in excess of the costs paid for the drugs or medicines plus an administrative cost of greater than 10 percent of the cost of said drugs or medicines (effective 6/9/99 for one year, stayed).

August

- 10) *Scott A. Salkind, DO*; based on violation of previous consent order, filed 10/24/97, requiring abstinence from alcohol and all controlled substances (effective 8/2/99 for an indefinite period).
- 11) *Edward M. Andujar, MD*; based on allegations of billing for payment not justified by services rendered, intravenous therapy and other forms of treatment rendered when not warranted or when contraindicated, permitting unlicensed persons to perform services which may only be performed by licensed personnel, and other acts involving medical negligence and billing irregularities (effective 8/12/99 for two years, stayed).
- 12) *Mitchell J. Grayson, MD*; based on allegations including (in connection with liposuction) multiple acts of negligence, gross negligence and record alteration (effective 8/12/99 for two years, stayed).
- 13) *Albert L. Greenwood, MD*; based on the suspension of his New York license for professional misconduct (prescribing a Schedule II controlled substance in immense and alarming quantities and in a manner crafted to avoid detection); (effective 8/18/99 for 30 days, stayed).

- 14) *James Gorelick, MD*; based on the suspension of his Florida license for sexual assault upon three patients (effective 8/31/99 for an indefinite period).
- 15) *Mark S. Josovitz, MD*; based on a suspension of his Tennessee license for numerous counts of unprofessional, dishonorable, dangerous and unethical conduct resulting from conduct including intoxication and chemical dependency (effective 8/31/99 for an indefinite period).

September

- 16) *Frederick D. Gangemi, MD*; based on the finding that his continued practice poses a clear and imminent danger to the public health, safety and welfare (effective 9/8/99 for an indefinite period).
- 17) *Allen C. Pomerantz, MD*; based on the revocation of his New York license for professional misconduct (engaging in "unacceptable practices" and receiving overpayments from Medicaid through participation in an illegal fee-splitting arrangement); (effective 9/14/99 for one year, stayed).
- 18) *Nicholas V. Basso, DO*; based on a relapse into substance abuse (effective 9/28/99 for an indefinite period).

October

- 19) *Eric Jacobson, MD*; based on allegations of holding himself out as providing interpretations of "diagnostic musculoskeletal ultrasound testing" as an appropriate means of diagnosing soft tissue injuries, although it was not and to date is not so recognized; and allegations of other violations of statutes, regulations and accepted standards of practice (effective 10/14/99 for two years with part stayed).

November

- 20) *Divyang N. Trivedi, MD*; based on the revocation of his California license for excessive use of diagnostic or treatment facilities (effective 11/10/99 for 30 months, stayed).
- 21) *George A. Carr, III, MD*; based on the finding in New York of filing false claims for unfurnished medical care, services or supplies or for medical care, services or supplies provided at a frequency not medically necessary; failure to maintain necessary records (effective 11/15/99 for two years).

December

- 22) *Gary Fischman, DPM*; based on a conviction in New York State for grand larceny in the fourth degree and offering a false instrument for filing in the first degree; and admission to the New York Board to one charge of professional misconduct based on his conviction (effective 12/21/99 for three years with one month active, and the remainder stayed).
- 23) *Godofredo B. Perez, MD*; based on the suspension of his Pennsylvania license for failure to keep proper medical records and improper prescribing of CDS on multiple occasions (effective 12/23/99 for six months).
- 24) *Raphael Jewelewicz, MD*; based on the suspension of his New York license after admission to professional misconduct including sexual relations with patients and inappropriate prescribing (effective 12/29/99 for three years, stayed).
- 25) *Barbara A. Mazzella, MD*; based on the suspension of her Florida license after admission to charges that she had made deceptive, untrue or fraudulent representations in or related to the practice of medicine (effective 12/29/99 for six months, stayed).
- 26) *Santiago G. Urmaza, MD*; based on his censure and reprimand by the New York Board, and the limitation of his New York license, after a charge of practicing negligently on more than one occasion (effective 12/29/99 for one year, stayed).

Revocations

April

- 1) *Anthony Consalvo, Jr., DPM*; based on his plea of guilty to the charge of grand larceny in the fourth degree in the Supreme Court of the State of New York (fraudulent Medicaid billings from 1986 to 1992); (effective 4/16/99).
- 2) *Young I. Kim, MD*; based on the revocation of his New York license due to charges of abusing and harassing patients, practicing medicine fraudulently and with moral unfitness and knowingly filing false applications for professional privileges (effective 4/16/99).
- 3) *Steven Schultz, MD*; based on the revocation of his New York license due to his failure to comply with a psychiatric evaluation ordered by the New York State Board for Professional Medical Conduct (effective 4/16/99).

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August

- 4) *Avtandil Papiasvili, MD*; based on the revocation of his New York license after entering a plea of guilty to charges of grand larceny in the third degree in New York State Supreme Court (submitting false claims to Medicaid); (effective 8/6/99).
- 5) *Tan Chen, MD*; based on his conviction for a crime involving moral turpitude or a crime relating adversely to the activity regulated by the Board (guilty pleas to three counts of fourth-degree criminal sexual contact with patients); (effective 8/11/99).
- 6) *Boonlua Lucktong, MD*; based on the suspension and revocation of his West Virginia license due to multiple acts of negligence or incompetence and failure to obtain a passing score on the SPEX examination (effective 8/31/99).
- 7) *Moshe B. Mirilashvili, MD*; based on the revocation of his New York license due to 13 counts of professional misconduct including repeated acts of negligence, acts of gross negligence, failure to maintain records and engaging in the use of fraud (effective 8/31/99).

September

- 8) *Tadeusz M. Basecki, MD*; based on the surrender of his New York license after admission to charges of professional misconduct (forced sexual contact with minor females); (effective 9/29/99).
- 9) *Vincent A. Giannattasio, MD*; based on the surrender of his Wisconsin license due to charges of unprofessional conduct and the revocation of his New York State license (effective 9/29/99).
- 10) *Nokuzola S. Ntshona, MD*; based on surrender of her New York license and agreement not to contest the charge of professional misconduct in the State of New York, which was based on her criminal conviction for Medicaid fraud (effective 9/29/99).

October

- 11) *Aruna Mishra, MD*; based on admissions to Medicaid fraud and engaging in illusory and dangerous practice (effective 10/25/99).
- 12) *Lee J. Frankel, DPM*; based on findings of dishonesty, fraud and deception; a conviction for a crime involving moral turpitude; and professional misconduct (effective 10/29/99).

December

- 13) *Joseph Picciotti, DPM*; based on convictions in the US District Court in Camden for conspiracy to defraud the United States, soliciting and receiving kickbacks, and mail fraud (effective 12/17/99).
- 14) *Shing C. Ho, MD*; based on the surrender of his New York license in 1998 after admission to gross negligence, negligence on more than one occasion, fraud, and failure to meet acceptable standards of care (effective 12/29/99).
- 15) *Alice M. Piasecki, MD*; based on the revocation of her New York license due to Medicaid fraud, negligence on more than one occasion, practicing the profession with incompetence on more than one occasion and performing unnecessary tests and treatments (effective 12/29/99).
- 16) *Saverio J. Senape, MD*; based on the revocation of his New York license after his conviction on two counts of grand larceny, falsifying business records, offering a false instrument for filing and at least 37 counts of aiding/abetting an unauthorized person in the practice of a profession (effective 12/29/99).

Surrendered

January

- 1) *Candida Aguirre-Medrano, MD*; voluntary surrender of her license based on allegations of repeated acts of malpractice and professional misconduct (effective 1/6/99 for an indefinite period).

April

- 2) *Carmine Spedaliere, MD*; based on allegations of gross/repeated malpractice, negligence, incompetence, professional misconduct, and lack of good moral character (effective 4/21/99 for an indefinite period).

June

- 3) *Sidney A. Nelson, MD*; surrender of his license following a suspension based on a finding that his continued practice of medicine palpably presents a clear and imminent danger to the public (suspension effective 6/9/99 with subsequent surrender of his license on 10/22/99).
- 4) *Daniel J. Zimmerman, MD*; based on his indictment by the Drug Enforcement Administration for receiving large amounts of a controlled dangerous substance

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(CDS) at his residence over a two-year period (effective 6/25/99 for an indefinite period).

August

- 5) *Edward S. Feldner, MD*; based on his admission that he had diverted/prescribed a controlled dangerous substance (CDS) for his own use (effective 8/31/99 for an indefinite period).

October

- 6) *Yakov Chuzhim, MD*; based on allegations of a relapse into substance abuse (effective 10/29/99 for an indefinite period).

November

- 7) *Stephen Saul, DPM*; based on allegations of impairment due to substance abuse (twice tested positive for cocaine); (effective 11/24/99 for an indefinite period).
- 8) *Clifford R. Lipman, MD*; based on several relapses into abuse of alcohol and Percocet, which necessitated in-patient treatment; failure to inform the Board of these relapses on his most recent biennial renewal application (effective 11/29/99 for an indefinite period).
- 9) *Salvatore R. Petrucelli, MD*; based on a relapse into alcohol abuse (effective 11/29/99 for an indefinite period).

December

- 10) *Raymond D. Reiter, MD*; based on his arrest on charges of sexual assault of and criminal sexual contact with four female patients (effective 12/23/99 for an indefinite period). ■

An Overview of the Disciplinary Process *By Glenn A. Farrell, Esq.*

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The Complaint

A complaint may come directly to the Board, to the New Jersey Division of Consumer Affairs (Consumer Affairs) or to the Office of the Attorney General (OAG). Typically, complaints are filed by individuals who have been treated or who are currently being treated by a Board licensee, although occasionally they are filed by third parties such as family members, insurance or managed-care companies.

Board Options

Upon receipt of a complaint, the Board has a number of courses of action it may take. These include: (1) closing the matter administratively after a PEC obtains and considers the licensee's version of events (A Preliminary Evaluation Committee is a committee of the Board which acts in a preliminary investigative capacity.); (2) inviting the licensee to an investigative inquiry before a PEC; (3) referring the matter to Consumer Affairs' Enforcement Bureau for investigation; or (4) referring the matter to a Board expert for review. The Board may also choose a combination of these actions, all of which are designed to gather more information. Another alternative is to refer the matter to the OAG for the preparation and filing of an administrative complaint. In emergency circumstances when a licensee's alleged misconduct is so extreme as to constitute a clear and imminent danger to the public, after affording the licensee a hearing, the Board may suspend or limit a licensee temporarily pending the completion of a full formal hearing which usually occurs at the Office of Administrative Law (OAL).

Investigative Inquiry (PEC Appearance)

An investigative inquiry is a confidential, fact-finding procedure conducted by the Board in an effort to ascertain the facts underlying a complaint. A PEC is the most common investigative inquiry used by the Board. After its investigation, the PEC submits a recommendation for consideration by the full Board. At an investigative inquiry, the licensee is asked to appear and give testimony under oath. The licensee is advised that he or she may be represented by an attorney, and that his or her sworn testimony will be transcribed by a certified shorthand reporter. In some instances, the Board may request that the complainant, or any other person with knowledge of the case, appear to give testimony at an investigative inquiry. By statute, this investigative inquiry is confidential unless a formal disciplinary action is initiated.

Continued on the next page

Results of an Investigative Inquiry (PEC Appearance)

An investigative inquiry may result in a finding of: (1) no probable cause or insufficient cause which means no disciplinary action will be taken; or (2) probable cause for further action. In the latter case, Board action may include: (a) an expression of Board disapproval (letter of admonishment, which is placed in the licensee's file and is not made public); (b) a voluntary agreement (public Consent Order) to certain action or penalty ranging from the correction of a deficiency by the subject of the complaint or the restoration of money or property to the offended party, to more serious agreed-upon sanctions; or (c) a decision by the Board to proceed to a formal hearing because of the seriousness of the alleged violations or an inability to reach an agreement between the Board's attorneys and the subject of the complaint.

Formal Hearings

A formal hearing is a trial-type procedure which follows the filing of a formal complaint by the Attorney General. It always involves a contested case in which the licensee defends him/herself against the charges brought against him or her. A formal hearing occurs when one or more of the following conditions are met: (1) the Board believes the complaint is sufficiently serious to require formal adjudication; (2) the licensee does not respond to the Board's letters about the complaint and the Board believes there are sufficient grounds for further action; (3) an investigative inquiry has been held, but it fails to result in an agreed-upon settlement; or (4) the licensee demands a formal hearing. A licensee has the right to a hearing in any action which may result in any public disciplinary sanction against his or her license.

Procedure for a Formal Hearing

In a contested case, licensees are entitled to receive notice in the form of a complaint, stating under what legal authority and jurisdiction the hearing will be held, and containing a statement of what is being charged. The Attorney General or the respondent (licensee) may ask the Board to issue subpoenas to compel the attendance of witnesses or the production of books, records or documents. Typically, formal hearings are held before an administrative law judge (ALJ) in the Office of Administrative Law (OAL) who makes an initial decision which is considered a recommendation to the Board. The Board may accept, modify or reject that initial decision after reviewing the record.

Sanctions Available to the Board

In general, the Board can impose disciplinary sanctions on the basis of gross negligence, gross malpractice or repeated acts of negligence, malpractice or incompetence, engaging in dishonesty, factual misrepresentations, professional misconduct, conviction for committing certain crimes or based upon the suspension or revocation of one's license

in another state. Other specific acts, as set forth in the Board's enabling legislation, regulations and the Uniform Enforcement Act, may also provide the basis for the imposition of disciplinary sanctions.

After affording the licensee the opportunity to be heard and determining that a violation has occurred, the Board may impose a variety of penalties. Information regarding public orders or sanctions is available to the public upon request.

Private Sanctions

Private sanctions include issuing: (1) a letter of warning; (2) a letter of admonishment; or (3) a letter of advice. The imposition of private sanctions does not require a hearing. Furthermore, records of private discipline are not available to the public and do not enter the public domain.

Public Sanctions

Public sanctions include: (1) reprimanding the subject of the complaint; (2) revoking or suspending the subject's license. (The Board may, however, elect to stay a suspension or a portion of a suspension on probationary conditions.); (3) assessing civil penalties of not more than \$10,000 for the first offense and not more than \$20,000 for the second and for each subsequent offense; (4) ordering a licensee to cease and desist from future violations and taking other corrective action as may be necessary; (5) ordering the restoration to aggrieved persons of moneys or property acquired by the violator through an unlawful act or practice (restitution); and (6) ordering a licensee, as a condition for continued licensure, to take courses in continuing education or to secure any necessary medical or other professional treatment as necessary.

Nondisciplinary Matters

A licensee suffering from impairment by drug, alcohol, psychological or psychiatric problems or who refers him/herself to an approved recovery institution may be eligible to participate in the Board's Impairment Review Committee (IRC). The IRC is an alternative to public discipline in appropriate cases.

Conclusion

By statute, at least 16 of the Board's 21 members are required to be Board licensees. The remaining Board members consist of three public members, the Commissioner of Health or his designee and an executive department designee. Board representation is sensitive to both its licensees and to the public. The function of the disciplinary process is to protect the public in a way which does justice not only to the public, but also to Board licensees.

Glenn A. Farrell is a public member of the Board and is a practicing attorney. This article is for general informational purposes and is not intended to provide legal advice.

TERMINATION of a Doctor/Patient Relationship

By R. J. Fernandez, M.D.

Despite numerous discussions with a patient, he or she continues to be disruptive to office staff and noncompliant with diagnostic tests, treatments, medications prescribed and/or follow-up appointments. What can a doctor do?

When all other attempts at resolution have failed, a licensee can consider terminating the doctor/patient relationship.

A physician has the right to end a doctor/patient relationship in many circumstances provided certain procedures are followed that ensure the patient receives adequate protection when the relationship is terminated.

The problem has been how to protect the continued well-being of the patient, while recognizing the licensee's option to terminate the relationship when conditions indicate that this is appropriate.

In an attempt to provide general guidance to its licensees, the New Jersey State Board of Medical Examiners has adopted a new rule (N.J.A.C. 13:35 - 6.22) concerning the termination of a licensee-patient relationship. In general, once a doctor/patient relationship exists (as defined in the regulations), the licensee may terminate the doctor/patient relationship by providing written notification to the pa-

tient. To confirm appropriate patient notification, the notice of termination must be sent by certified mail, return receipt requested, no less than 30 days prior to termination. During the 30-day period until the date on which services are to be terminated, a licensee must continue to provide all emergency care and services to the patient including an adequate supply of medication, if such is clinically indicated. In all cases of termination, it is required that access to and transfer of patient records be handled by the licensee as per N.J.A.C. 13:35-6.5. Furthermore, if a patient requests assistance, a licensee is required to make a reasonable effort to provide the patient with referrals for ongoing clinical care.

The regulation was approved by the Board at its January 12, 2000 meeting. The regulation will become effective, and licensees will be required to comply with the rule, once it is published in the New Jersey Register.

While providing a general review of the new regulation, this article should not be considered a substitute for becoming familiar with the entire rule. Many issues addressed in the regulation, such as cases in which a licensee may not terminate a relationship, are not discussed here, and it is advised that licensees read the regulation thoroughly to understand areas particularly applicable to their practice.

Usage of Uniform Prescription Blanks Required

The "Uniform Prescription Blanks Law," which became effective on March 1, 1997, requires that all prescriptions written in New Jersey be issued on New Jersey Prescription Blanks (NJPB's) subject to stringent security controls, in order to deter prescription drug abuse and prescription forgery. The major provisions of the law follow:

1. All licensed New Jersey practitioners, and health care facilities authorized by the State Department of Health to issue prescriptions, must use NJPB's for all written prescriptions.
2. Written prescriptions that are issued in New Jersey will be honored at pharmacies in this State only if they are written on NJPB's. Telephoned-in and electronically transmitted prescriptions are exempt so long as the prescriber provides his or her license number and/or DEA number, as appropriate.
3. Each NJPB must include a practitioner's professional license number or health care facility "unique provider number." The latter is assigned by the Division of Consumer Affairs to those facilities licensed by the State Department of Health.
4. NJPB's may be purchased only from printer/vendors approved by Consumer Affairs. Anyone printing or issuing prescription blanks without authorization may be in violation of N.J.S.A. 2C:21-1.
5. Forgery or theft of NJPB's are considered crimes of the third degree which may be punishable by a term of imprisonment of between three and five years.
6. All licensed prescribers and health care facilities receiving NJPB's must maintain precise records reflecting the ordering, receipt, maintenance and distribution of NJPB pads. NJPB's should be stored in secure locations.

7. All licensed prescribers and health care facilities must notify the Office of Drug Control (NJPB Unit 973-504-6558) within 72 hours of being made aware that any NJPB has been stolen or forged and they also must complete an NJPB Incident Report Form.

The Uniform Prescription Blanks Law has been successful. Several arrests and prosecutions have transpired as a result of the NJPB Incident Reporting System which has been implemented. In addition, an official report submitted to Governor Whitman reflected that the State-funded programs (Medicaid, PAAD and General Assistance) saved \$6 million in the program's first 12 months, as a result of the new law. For these trends to continue, physicians are reminded to:

1. place orders for NJPB's with approved printer/vendors only when necessary to replenish prescription blank supplies;
2. check "filled orders" for NJPB's immediately following receipt from printer/vendors, to be sure that they have received the correct quantity and that the quality of the blanks is satisfactory;
3. contact the NJPB Unit if orders are filled unsatisfactorily or if unsolicited prescription blanks, preprinted with various drug product names or otherwise, are received from drug manufacturers or anyone;
4. maintain blank NJPB's in a safe and secured area where they cannot be accessed by unauthorized personnel. (If the likelihood of NJPB pilferage or forgery is a paramount concern, consider placing a special order in which each blank form will be numbered sequentially.); and
5. promptly telephone the NJPB Unit at 973-504-6558 upon discovering that a prescription blank has been stolen or forged to ensure expedient completion of an "NJPB Incident Report," resulting in timely notification of the appropriate authorities.



FAILURE TO REPAY STUDENT LOANS

Governor Christine Todd Whitman has signed into law P.L. 1999, c. 54, effective June 8, 1999, which permits the Director of the Division of Consumer Affairs, or any of the professional boards which issue licenses, to suspend any licensee who defaults on a state or federal education loan. The license will not be reinstated until the licensee provides the executive director of the board with a written release, issued by the lender or guarantor, which says that he or she has paid the loan in full, or is making payments in accordance with a repayment agreement approved by the lender or guarantor.

New Jersey Kidcare Works for New Jersey's Uninsured Children

The NJ KidCare program is designed to help children receive the affordable quality healthcare they need to grow up healthy. Launched in February 1998, NJ KidCare offers health coverage for uninsured children 18 and under.

Based on families' income level, children may qualify for low- or no-cost health insurance coverage. For example, following recent expansions to the program, a family of four may earn up to \$58,450 a year and still qualify for the program.

Children who are found to be eligible receive access to a wide range of health care services through a health maintenance organization. These services may include: check-ups for healthy children, preventive care, hospitalization, X-rays, prescription drugs and vision and hearing services. Other healthcare services are also available, including behavioral health.

The State is currently sponsoring outreach efforts to generate community awareness of the program. More than 300 agencies based throughout the State serve as enrollment sites by assisting families with the application process. Partners include health, social, educational and community-based organizations, as well as private busi-

nesses, government agencies and schools. The feelings of trust and comfort generated by these organizations make them NJ KidCare's most valuable link to the thousands of parents, grandparents and guardians whose children or grandchildren need healthcare.

The NJ KidCare media campaign also promotes the program through TV, radio, newspaper and billboard advertisements. "We want to make NJ KidCare a household word," says Michele Guhl, Commissioner of the State Department of Human Services, which administers the program.

As advocates for quality healthcare, there are many ways that Board licensees can join the many efforts to help spread the word about NJ KidCare. For instance, licensees can display materials in their waiting room, or enclose information on NJ KidCare when billing patients who have uninsured children.

If you or your patients would like more information about eligibility or enrollment sites, or to request an application, please call NJ KidCare toll free at 1-800-701-0710.

To request materials for display or to discuss how you can become actively involved in the KidCare outreach effort, please call the Office of NJ KidCare at (609) 588-3526.